STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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COPIES MAILED TO COUNSEL OF RECORD 8/13/08

August 13, 2008

By Fax: 212-805-6181
Honorable Douglas F. Eaton
United States District Court
Southern District of New York
United States Courthouse
500 Pearl Street
New York, New York 10007

MEMO ENDORSED

Re: Hofelich v.Ercole, Supt., et. al., 06 CV 13697 (PKC)(DFE)
Hofelich v. Ercole, et. al., 08 CV 2193 (PKC)(DFE)

Your Honor:

I am an Assistant Attorney General in the Office of Andrew M. Cuomo, Attorney General of the State of New York, assigned to the defense of these matters. I write on behalf of defendants to respectfully request a sixty (60) day extension of the discovery schedule from August 30, 2008 to October 31, 2008. Defendants also respectfully request that the deadline for the submission of any dispositive motions to Judge Castel be extended from September 30, 2008 to November 28, 2008.

An extension is necessary because the defendants have been unable to secure a complete copy of plaintiff's medical records. While defendants are in possession of the medical records from the New York State Department of Correctional Services (DOCS), we have been unable to secure plaintiff's medical records from Putnam Hospital Center. On November 28, 2007 and again on July 10, 2008, this office sent plaintiff an authorization for the release of his medical records from Putnam Hospital Center located in Carmel, New York. However, to date we have not received a signed authorization. Without the records from Putnam Hospital Center, the defendants are unable to conduct plaintiff's deposition. These records are integral to the litigation as plaintiff alleged he was admitted to Putnam Hospital due to severe blood loss

between April 7, 2006 and April 12, 2006.[1]

Additionally, defendants ask that the Court order plaintiff to provide the necessary authorization for his medical records from Putnam Hospital Center. A copy of the HIPAA authorization sent to plaintiff for his signature is attached for the Court's information.

I did not request the consent of the incarcerated plaintiff pro se to extend the discovery schedule and the deadline for the submission of any dispositive motions because I wanted to make these requests on behalf of the defendants forthwith. This is the defendants' first request for an extension of the discovery schedule and the dispositive motion submission date.

I thank the Court for its consideration in these matters.

Respectfully submitted,

Julinda Dawkins
Assistant Attorney General

Enc.

cc: Jason Hofelich
Plaintiff Pro Se
DIN #: 01-A-5996
Mid-State Correctional Facility
PO Box 2500
Marcy, NY 13403

MEMO ENDORSED 8/14/08

Approved (on behalf of Judge Peck)

SO ORDERED:

Hon. Andrew Jay Peck
United States Magistrate Judge

[1]See complaint bearing docket number 08 CV2193, Attachment at p. 4.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

Patient Name: **Jason Hofelich**	Date of Birth: **05/22/1971**	Social Security Number: **Din # 01 A 5996**

I, Jason Hofelich, hereby authorize the below-named individual or organization to disclose and release the above-named patient's health information, as described below, to the Attorney General of the State of New York, or to any Assistant Attorney General, or any representative, agent or designee of the Attorney General, _____, New York _____, for the purpose of litigation.

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS:

The complete therapy notes of the above-named patient, including therapy notes received from or that were created by another provider. All records, writings, or other information provided shall bear the certification or authentication of the physician releasing the information or of the head of the hospital, laboratory, department or bureau of the municipal corporation that is releasing the information, or of an employee delegated for that purpose.

I understand that the information in the patient's therapy notes may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), the virus that causes AIDS. I understand that confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. I understand that the information released or disclosed pursuant to this authorization may be subject to redisclosure by the recipient if the recipient is not a health care provider or health plan covered by law. Such redisclosure is restricted or limited by NYS Public Health Law Article 27-F. The information released or disclosed pursuant to this authorization may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This authorization shall remain in full force and effect until it expires five years from the date set forth below, unless otherwise stated.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage, or if another law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by Federal or State confidentiality rules.

The name and address of the health care provider authorized to release and disclose the requested health information is:

Putman Hospital Center

670 Stoneleigh Avenue

Carmel New York 10512

DATED: _____

_____
(Signature and, if appropriate, legal relationship to patient)

A COPY OF THIS AUTHORIZATION MAY BE ACCEPTED WITH THE SAME FORCE AND EFFECT AS THE ORIGINAL.